

MIRCal

Edit Flag Description Guide

INPATIENT DATA

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Version 15



Medical Information Reporting for California

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SUMMARY OF CHANGES VERSION 15

- Updated edit programs for Present on Admission reporting requirements
- Updated Age and Sex Edit Tables based on the Oct 2008 ICD-9-CM Code Updates

Changes Effective with discharges on or after July 1, 2008
(July 1, 2008-December 31, 2008 Report Period)

Transmittal Validation

Pages 8-9

- Streamlined the transmittal validation process to provide improved feedback to facilities:
 - Combined 2nd and 3rd levels of transmittal validation.
 - Record numbers will now be displayed on the Main Error Summary to help facilities quickly locate the record(s) in error.
- Updated file format error messages with the new file format specifications for Present on Admission and Principal Language Spoken.

Present on Admission (POA): Comparative Edit Program

Page 22 – Revised the following Comparative Edits. Changes are underlined:

- C028** The percentage of records reported with NO, UNKNOWN, and/or CLINICALLY UNDETERMINED for Principal Diagnosis Present on Admission Indicator is greater than 10% of the total number of Principal Diagnosis Indicators. Excludes POA reported as 'blank', 1 or E for Exempt Diagnosis Codes.
- C029:** Other Diagnosis Present on Admission Indicator is reported as 100% YES (Y). Excludes POA reported as 'blank', 1 or E for Exempt Diagnosis Codes.
- C030:** Increased percentage from 20% to 30% and revised description. Changes are underlined. The percentage of records reported with NO, UNKNOWN, and/or CLINICALLY UNDETERMINED (W) for Other Diagnosis Present on Admission is greater than 30% of the total number of Other Diagnosis Indicators. Excludes POA reported as 'blank', 1 or E for Exempt Diagnosis Codes.

Page 22: New POA Comparative Edits

Principal E-Code POA

- C040:** Principal E-Code Present on Admission Indicators are reported as 100% No (N). Excludes POA reported as 'blank', 1 or E for Exempt E-Codes.
- C041:** Principal E-Code Present on Admission Indicators are reported as 100% Unknown (U). Excludes POA reported as 'blank', 1 or E for Exempt E-Codes.
- C042:** Principal E-Code Present on Admission Indicators are reported as 100% Clinically Undetermined (W). Excludes POA reported as 'blank', 1 or E for Exempt E-Codes.

Other E-Code POA

- C043:** Other E-Code Present on Admission Indicators are reported as 100% No (N)
Excludes POA reported as 'blank', 1 or E for Exempt E-Codes.
- C044:** Other E-Code Present on Admission Indicators are reported as 100% Unknown (U).
Excludes POA reported as 'blank', 1 or E for Exempt E-Codes.
- C045:** Other E-Code Present on Admission Indicators are reported as 100% Clinically
Undetermined (W).
Excludes POA reported as 'blank', 1 or E for Exempt E-Codes.

New POA Standard Edits **Page 32**

- S129:** Principal Diagnosis code is exempt, but POA Indicator is not blank, or reported as 1 or E.
- S130:** Other Diagnosis code is exempt, but POA Indicator is not blank, or reported as 1 or E.
- S131:** Principal E-Code is exempt, but POA Indicator is not blank, or reported as 1 or E
- S132:** Other E-Code is exempt, but POA Indicator is not blank, or reported as 1 or E
- S134:** Principal Diagnosis is not exempt, but POA indicator is reported as 1 or E.
- S135:** Other Diagnosis is not exempt, but POA indicator reported as 1 or E.
- S136:** Principal E-Code is not exempt, but POA exempt indicator is reported as 1 or E.
- S137:** Other E-Code is not exempt, but POA exempt indicator is reported as 1 or E.

Age Edit Updates **Page 44**

<u>ICD-9-CM Diagnosis Code</u>	<u>Age at Admission Invalid if . . .</u>
V23.85	Age is less than 10 years old
V23.86	Age is less than 10 or greater than 70
V28.81-V28.89	Age is less than 10 or greater than 70
V51.0	Age is less than 15
V89.01-V89.09	Age is less than 10 or greater than 70
678.00-679.14	Age is less than 10 or greater than 70

Sex Edit Updates
Pages 49 & 51

ICD-9-CM Diagnosis Code

V15.21-V15.22
V88.01-V89.09

Sex Specific

Female
Female

ICD-9-CM Procedure Code

85.70-85.79

Sex Specific

Female

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I INTRODUCTION

There are currently nine (9) MIRCal edit programs applied to inpatient data. Data submitted on MIRCal, via file submission or manual record entry, are processed through the MIRCal edit programs. Each record is edited, and any errors found within the record are identified by edit flags.

This guide provides detailed information about each edit program, the applicable Error Tolerance Levels, and a list of the edit flags and their descriptions.

MIRCal Edit Programs:

Transmittal Validation

Licensing Check

Trend Edits

Comparative Edits

Records with a Blank or Invalid Principal Diagnosis

Standard Edits

Re-Admission Edits

Coding Edits

Exception Edits

II MIRCAL EDIT PROGRAMS AT-A-GLANCE

UNDERSTANDING THE MIRCAL EDIT PROGRAMS

Your data will be rejected if it fails any of the edit programs. "Fail" means your data is not at or below the established Error Tolerance Level (ETL). Understanding the edit programs and the reasons your data might fail is very important when determining the best way to correct errors.

If your report fails either the Transmittal Validation or Licensing Check, it will be rejected and will not be processed through the remaining edit programs.

Program	Description	Likely Cause of Failure
Transmittal Validation	<p>Checks for proper file format and compares the "Expected" (based on the Transmittal Page information) to "Actual" data submitted.</p> <ul style="list-style-type: none"> • Virus infected file • No data in file • Multiple files in a Zip file • Incorrect file format • Discrepancy in the number of records submitted vs. the number entered on the Transmittal screen. • One (1) or more records are reported with a Discharge Date that is blank, invalid, or outside the Report Period. • Incorrect Facility ID Number on one or more records • MIRCal Database capacity error 	Your data did not pass one or more of the transmittal validations.
Licensing Check	<p>Checks to make sure your data includes all the types of care and services for which your facility is licensed. For example, if your facility is licensed for Acute care, but no records are reported as Acute type of care, then your data will fail this program.</p> <p>NOTE: This program does not check for records that include a type of care for which your facility is <u>not</u> licensed. The Standard Edit program identifies this type of error.</p>	Your facility is licensed for a specific type of care, but that type of care is not being reported on any of your records.
Trend Edit (T flag)	<p>Compares the data in the current report period to the facility's historical data to identify uncharacteristic increases or decreases in percentages reported for certain data elements/categories.</p> <p><u>EXAMPLE:</u> In the Current Report Period, your facility reported 65% Non-Hispanic patients, but in the previous two (2) report periods, you reported only 20% Non-Hispanic patients. If this percentage difference between report periods is outside the "Allowable Difference", then either a Critical or Non-Critical Trend flag is generated. Non-Critical flags will not cause your data to fail this program, but one or more Critical flags will.</p>	Your data caused the program to generate one or more Critical Trend flags.

Program	Description	Likely Cause of Failure
Comparative Edit (C flag)	Based on the TOTAL records reported, checks for reasonable distribution of categories within each data element for the Current Report Period. <u>EXAMPLE:</u> If 100% of your records are reported with Patient Disposition-Routine, this program will generate a Comparative Edit flag and your data will fail.	Your data caused the program to generate one or more Comparative Edit flags.
Records with a Blank or Invalid Principal Diagnosis	This program identifies records with a Principal Diagnosis that is blank, invalid, reported with an "old" diagnosis code after the effective End Date; or reported with a "new" diagnosis code before the effective Begin Date. The erroneous Principal Diagnosis code will receive a critical S-flag.	One or more records with a Blank or Invalid Principal Diagnosis
Standard Edit (S flag)	Checks for data entry errors and inconsistencies of data reported within each record. <u>EXAMPLE:</u> Admit Date is AFTER the Discharge Date.	More than 2% of your records contain standard edit errors.
Coding Edit (V flag)	Checks for illogical combinations of ICD-9-CM codes. <u>EXAMPLE:</u> It is illogical for a record to have a Principal Diagnosis code for a normal birth and a Procedure Code for a C-section.	More than 2% of your records contain coding edit errors.
Readmission Edit (K flag)	Groups records that contain identical Social Security Numbers (SSNs), and then checks for inconsistencies between the records. <u>EXAMPLE:</u> Two records with the same SSN cannot have different Dates of Birth; either the SSN or the Date of Birth is incorrect. This program also checks for errors in transfers to a different type of care. <u>EXAMPLE:</u> A patient is transferred within your hospital from Acute Care to SN/IC on the same day. The Patient Disposition in record 1 is reported as "04 SN/IC within hospital", but the Source of Admission in record 2 is reported as "132 Home." This would cause a readmission error. The Source of Admission in record 2 should be reported as "51x Acute Inpatient within your hospital."	More than 2% of your records contain readmission edit errors.
Exception Edit (X flag)	Identifies inconsistencies or reporting levels in your data that may indicate errors. <u>EXAMPLE:</u> An Exception Edit will be generated if no records are reported with a ZIP Code of ZZZZZ (Homeless). If your facility did not treat any homeless patients during the report period, then this is not an error. However, if your facility did treat homeless patients, then the ZIP Code must be reported as ZZZZZ. Do not use XXXXX (Unknown) for Homeless patients.	There is no pass or fail for this program.

III TRANSMITTAL VALIDATION

OVERVIEW

Transmittal Validation consists of two (2) levels of validation: The first level checks files for viruses and for empty, incomplete or multiple files. The second level checks for proper file format, discrepancies in the number of records submitted, blank and invalid discharge dates, and incorrect facility ID numbers.

Error Tolerance Level: Data must pass both levels of validation before continuing through the remaining MIRCal edit programs.

How do I know if my data failed Transmittal Validation?

Access the "Main Error Summary" to see if your data passed or failed Transmittal Validation. If the data failed Transmittal Validation, the Summary will display the error message(s) and record number(s) that contain the error.

- Up to 20 records are listed.
- If there more than 20 records with a transmittal error, then the following message will be displayed:

There are more than 20 records with a transmittal error. Only the first 20 records with errors are listed.

To access this Summary: click on "Main Error Summary" on the Main Menu.

FIRST LEVEL OF TRANSMITTAL EDITS

If the data fails any one of these transmittal edits, it will be rejected immediately and will not be processed through the Second Level of transmittal edits.

- Virus infected file
- Empty file (no data contained in the file)
- Multiple files in a Zip file

Once data passes the first level of edits, it will continue on to the second level of Transmittal Validation.

SECOND LEVEL OF TRANSMITTAL EDITS

Data will be rejected if it fails one or more of the following edits. Data must pass Transmittal Validation before continuing on to the remaining MIRCal edit programs.

- Incorrect File Format
- Non-ASCII character
- Discrepancy in Number of Records submitted
- Blank and Invalid Discharge Dates
- Incorrect Facility ID Number
- MIRCal Database capacity error

TRANSMITTAL ERROR MESSAGES

NOTE: For additional information on Transmittal Errors and how to correct them, please see the *Troubleshooting Guide for Transmittal Errors*, Rev 11/08 which can be found on the MIRCal website at <http://www.oshpd.ca.gov/HID/MIRCal/ManualsGuides.html>.

<i>Transmittal Edit</i>	<i>Error Message (Displayed on Main Error Summary)</i>
I. FIRST LEVEL OF EDITING:	
Checks for viruses	Virus infected file. Transmission of data was terminated.
Does the file contain data? (Empty file)	No data contained in the file
Multiple files in a Zip file?	Zip file contains multiple files
II. SECOND LEVEL OF EDITING: To easily locate the error, the Main Error Summary will display the Record Number(s) that contain a transmittal error. Up to 20 records are listed.	
Incorrect file format	File contains non-ASCII character(s)
Incorrect file format	Record length is more than 670 bytes
Incorrect file format	Record length is less than 670 bytes
Incorrect file format	No Carriage Control at byte 671
Incorrect file format	No Line Feed at byte 672
Discrepancy in the total number of records submitted	Total number of records submitted does not match the number of records entered on the Transmittal screen. The "Number of Records" column displays the number entered by the User.
Records with a Discharge Date outside the Report Period	One or more records are reported with a Discharge Date that is blank, invalid, or outside the Report Period.
Incorrect Facility ID Number	Incorrect Facility ID Number reported on one or more records. NOTE: On the Main Error Summary, the "Number of Records" column will display the Facility ID Number reported on the record in error.
MIRCal database capacity error	MIRCal Database error. The number of records in the MIRCal database does not match the number of records submitted. Contact your OSHPD analyst immediately.

IV LICENSING CHECK

OVERVIEW

The Licensing Check edits your facility's data against OSHPD's Licensing File to verify that the data reported is consistent with the Types of Care and Services for which it is licensed.

Error Tolerance Level: Data will fail the Licensing Check if it does not match OSHPD's licensing information, and all further editing is terminated.

Once the data passes the Licensing Check, it will continue through the remaining MIRCal Edit Programs.

NOTE: The Licensing Check does not edit records that include a Type of Care or Service for which your facility is not licensed. This is checked in the Standard Edit Program and is identified by an S flag.

How do I know if my data failed the Licensing Check?

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Licensing Check. The Summary displays either "Pass" or "Fail" for this edit program. If data has failed, the applicable error message(s) is also be displayed.

To access this Summary: click on "Main Error Summary" on the Main Menu.

If it is determined that the data submitted is correct as reported, please contact your OSHPD analyst to explain the licensing changes.

See next page for a list of the Licensing Check error messages and explanations...

LICENSING CHECK ERROR MESSAGES

<i>Licensing Check (Message displayed on Main Error Summary)</i>	<i>Explanation</i>
No records reported in Type of Care 1	Hospital is licensed for Acute Care but there are no records reported in this type of care.
No records reported in Type of Care 3	Hospital is licensed for Skilled Nursing/Intermediate Care but there are no records reported in this type of care.
No records reported in Type of Care 4	Hospital is licensed for Psychiatric Care but there are no records reported in this type of care.
No records reported in Type of Care 5	Hospital is licensed for Chemical Dependency Care but there are no records reported in this type of care.
No records reported in Type of Care 6	Hospital is licensed for Physical Rehabilitation Care but there are no records reported in this type of care.
No records reported in Source of Admission – Your ER, but your facility is licensed for Emergency Department Services	Hospital is licensed as a Basic or Comprehensive Emergency Department, but there are no admits through "Your ER".
Discrepancy in licensing information between facility and OSHPD	The Types of Care and Services reported do not match OSHPD's records. Contact your OSHPD analyst to resolve this licensing issue.

V TREND EDIT PROGRAM

OVERVIEW

The Trend Edit Program is designed to check for inconsistencies in data by comparing data submitted in the current report period to data submitted in the last two (2) (historical) report periods. If the difference between the current data and the historical data is more than a specified percentage, then a T (critical) or TW (non-critical) flag is applied to that data element or data element category. The facility must review any critical T flags in the data and verify whether or not the data is correct as reported.

ALLOWABLE DIFFERENCE: The Allowable Difference is based on Facility Size. Only the T003/TW03 and T004/TW04 flags use an "Allowable Difference" when comparing the current data to historical data. For more information, please refer to "Facility Size" and "Allowable Differences" under the DEFINITIONS/REPORTS in this section.

FIXED PERCENTAGE: All other Trend Flags use **FIXED** Percentages regardless of facility size. Please refer to the "Trend Edit Flags and Descriptions" table in this guide for a complete description of the flags.

Error Tolerance Level: Data will fail the Trend Edit Program if one or more Critical Trend Flags (T) are identified in the data.

How do I know if my data failed the Trend Edit Program?

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Trend Edit Program. The Summary will display either "Pass" or "Fail" for this edit program. For "Fail" status, the Summary also displays the number of trend edit flags identified in the data.

To access this Summary: click on "Main Error Summary" on the Main Menu.

The Trend Edit Program will not apply edits to a data element if:

- A data element in the current report period has a Modification or Non-Compliance
- The current report period is less than 90 days. Conversely, an historical report period that is less than 90 days will not be used for trend analysis.
- There is no historical data for the facility (e.g., new facility)

DEFINITIONS AND REPORTS

Critical Trend (T) Flag

A "T" flag, followed by a 3-digit number, identifies a Critical Trend Edit Flag.

A T-flag will result when the current data fails the Trend Edit in both historical report periods or it fails the Trend Edit against the only available historical report period.

The affected data element category will receive the applicable T-Flag.

Trend Warning (TW) Flag (Non-Critical Error)

A "TW" flag, followed by a 2-digit number, identifies a Warning (Non-Critical) Trend Edit Flag. A **TW-flag will NOT cause the data to be rejected**. These flags are "warnings" that alert the facility to review possible errors in the data.

When will the data get a TW flag?

A TW-flag will result when the data FAILS the Trend Validation in the 1st historical report period but PASSES the Trend Validation in the 2nd historical report period, or vice-versa. In other words, a TW flag is applied when the current data Passes and Fails the same trend edit when compared to data in two (2) previous historical report periods.

Trend Flags on the Race, ZIP Code, and Prehospital Care and Resuscitation (DNR) data elements are always Warning Flags (TW01, TW02, TW03, and TW04), whether they fail the trend edit in one or both historical report periods.

Facility Size

This is the total number of records submitted by a facility for the current report period. OSHPD classifies facility size in nine (9) categories:

Hospital Size	Total Records Reported	Allowable Difference Applies only to T003/TW03 and T004/TW04 flags
Micro Small Hospital	1 to 50	40%
Very Very Small Hospital	51 to 100	20%
Very Small	101 to 250	15%
Small	251 to 500	12%
Medium	501 to 1000	10%
Large	1001 to 2500	8%
Very Large	2501 to 5000	7%
Super Large	5001 to 10000	6%
Ultra Large	10001 and up	5%

Allowable Difference

The amount of increase or decrease that the MIRCal System will allow between current data and historical data reported by a facility for a particular data element category.

IMPORTANT: For the T003/TW03 and T004/TW04 flags, the Allowable Difference is based on facility size—the larger the facility, the smaller the Allowable Difference.

How does MIRCal determine that a data element category failed a Trend Edit?

After MIRCal calculates the current and historical percentages for the data element category, it subtracts the Current Percentage reported from the Historical Percentage reported and compares the difference. If the calculated difference is outside the "Allowable Difference" (too high or too low), then a "T" or "TW" flag is applied. The Trend Edit Summary displays all the data element categories that have been flagged with a T or TW flag.

Use the Data Distribution Report in conjunction with the Trend Edit Summary Report, to help you determine if the data is in error or is correct as reported.

Trend Edit Summary Report

This report identifies the data element categories that have been flagged with a T or TW flag. The report is in alphabetical order by Data Element and includes the percentage or number of records reported for the Current Report Period; the “Allowable Difference”; and the percentages or numbers from the corresponding historical report period(s).

To access this report: From the Main Menu, click on “Error Reports”, then under “Edit Programs-Trend Edits (T)”, click on “View” under “Summary Report”. You can print and/or save this PDF report.

Data Distribution Report

This is a 3-page report that displays each data element and lists the numerical and percentage breakdown of records within each data element category. Use this report to compare the data element categories that have been flagged with a “T” or “TW” flag to those categories (within the same data element) that were not flagged. It also may be useful to compare the “current” Data Distribution Report to “historical” Data Distribution Report(s) and look for any questionable increases or decreases in data element categories.

To access this report: From the Main Menu, click on “Error Reports”, then under Informational Reports, click on “View” next to “Data Distribution Report”. You can print and/or save this PDF report.

Report by Selected Data Element (custom report)

When reviewing the Trend Summary Report, you may need to review records associated with the Trend Edit Flag. For example, Type of Admission (TOA)-Scheduled has a T003 flag— “the percentage reported is lower than expected based on your historical data.” In order to determine whether or not this is an error, you may want to review all records reported as TOA-Unscheduled to see if some of these records need to be corrected to TOA-Scheduled, or to confirm if your data is correct as reported.

You may need to contact your OSHPD analyst and request a “Report by Selected Data Element”. This custom report, (all records reported as TOA-Unscheduled), can be generated and posted on MIRCal. It can then be accessed by the facility and used for Trend Edit error analysis. The report can only be accessed by the requesting facility.

NOTE: *If it is determined that the current data is correct as reported, please contact your OSHPD analyst to explain.*

TREND EDIT FLAGS AND DESCRIPTIONS

Critical Flags are identified as a T flag

Warning (Non-Critical) flags are identified as a TW flag

<i>Trend Edit Flag</i>	<i>Description</i>
T001	The current percentage reported for this data element category is ZERO, but your hospital's historical data shows data reported.
TW01	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T002	The current percentage reported for this data element category is greater than 2%, but your hospital's historical data shows ZERO records reported in this category.
TW02	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T003	The current percentage reported for this data element category is lower than expected, based on your hospital's historical data.
TW03	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T004	The current percentage reported for this data element category is greater than expected, based on your hospital's historical data reported.
TW04	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T005	<u>Total number of records submitted decreased</u> more than 20%, based on your hospital's historical data.
TW05	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T006	<u>Total number of records submitted increased</u> more than 20%, based on your hospital's historical data.
TW06	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T007	<u>Average Number of Other Diagnoses per Record decreased</u> more than 2 diagnoses per record, based on your hospital's historical data.
TW07	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T008	<u>Average Number of Other Procedures per Record decreased</u> more than 2 procedures per record, based on your hospital's historical data.
TW08	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T009	<u>Average Number of Other E-Codes per Record decreased</u> more than 2 E-Codes per record, based on your hospital's historical data.

Trend Edit Flag	Description
TW09	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T010	<u>Average Percentage of Principal Procedures decreased</u> more than 5 percentage points, based on your hospital's historical data.
TW10	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T011	<u>Average Percentage of Principal E-Codes decreased</u> more than 5 percentage points, based on your hospital's historical data.
TW11	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T012	<u>Average Length of Stay** decreased</u> more than expected. The decrease is more than 50%, based on your hospital's historical data.
TW12	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T013	<u>Average Length of Stay** increased</u> more than expected. The increase is more than 50%, based on your hospital's historical data.
TW13	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T014	<u>Adjusted Charge per Day** decreased</u> more than expected. The decrease is more than 50%, based on your hospital's historical data.
TW14	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T015	<u>Adjusted Charge per Day** increased</u> more than expected. The increase is more than 50%, based on your hospital's historical data.
TW15	Same description as above, but data failed this Trend Edit in only one (1) historical report period.

**** Calculations for Average Length of Stay and Adjusted Charger per Day:**

Average Length of Stay (ALOS): The ALOS is calculated by dividing the total number of discharge days by the total number of discharges reported by the facility.

NOTE: Length of Stay equals Discharge Date minus Admit Date. If the Discharge Date is the same as the Admit Date, then the length of stay is one day.

Adjusted Charge per Day (Adj C/D): The sum of the Adjusted Total Charges divided by Total Discharge Days

NOTE: Adjusted Total Charges: OSHPD regulations require that only the total charges for the last 365 days are to be reported. This is calculated by dividing the Total Charges by 365 to **determine the average** charge per day. This average charge per day is then multiplied by the patient's actual length of stay. The result is the Adjusted Total Charges.

VI COMPARATIVE EDIT PROGRAM

OVERVIEW

The Comparative Edit Program evaluates data for “reasonable” distribution of data within each data element category for the current report period. If the percentage reported is greater than expected, then the data element category will fail the Comparative Edit. Comparative Edits are not applied to Blank or Invalid data.

A C-Flag, followed by a 3-digit number, identifies Comparative Edits.

Error Tolerance Level: Data will fail the Comparative Edit Program if one or more Comparative Edit Flags are identified in the data.

How do I know if my data failed the Comparative Edit Program?

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Comparative Edits. The Summary displays either “Pass” or “Fail” for this edit program. For “Fail” status, the Summary also displays the number of comparative edit flags identified in the data.

To access this Summary: click on "Main Error Summary" on the Main Menu.

DEFINITIONS AND REPORTS

Allowable Percentage

This is the percentage of increase in a data element category that the MIRCal System allows before flagging it as a **possible error**. Depending on the Comparative Edit, the “Allowable Percentage” is either based on facility size; or is a “fixed” percentage that applies to all facilities regardless of size.

Facility Size

This is the total number of records submitted by a facility for the current report period. OSHPD classifies facility size in the following five (5) categories:

Hospital Size	Total Records Reported	Allowable Percentage
Very Small Hospital	1 to 100 discharges	25%
Small Hospital	101 to 500 discharges	20%
Medium Hospital	501 to 1,000 discharges	15%
Large Hospital	1,001 to 5,000 discharges	10%
Very Large Hospital	5,001 and more discharges	5%

How does MIRCal determine if a data element category failed a Comparative Edit?

- Based on the total records reported, MIRCal calculates the percentage of records reported in a data element category. If the reported percentage is above the Allowable Percentage, then a C-flag is applied to that data element category.
- The Comparative Edit Summary Report displays all the data element categories that have been flagged with a C flag.

Example of a Comparative Edit that uses an Allowable Percentage based on Facility Size:

The Total Records submitted by Facility A is 1,200 (Facility Size); therefore, their Allowable Percentage is 10%.

C005: This edit checks to see if the percentage of records with Unknown-Ethnicity is above the percentage expected for the facility. In this example 10% is the expected percentage for Facility A.

Facility A reported 12.5% of their records with an Unknown Ethnicity. Since their Allowable Percentage is 10%, this data element category will receive a C005 Flag.

Example of a Comparative Edit that is based on a fixed percentage:

C012: All records (100%) are reported in one category for Source of Admission - Site.

If a facility reports 100% of their records as Source of Admission-Prison/Jail, then the data will receive a C012 flag. The Facility Size is irrelevant for this edit— facilities with either 100 records or 10,000 records will both fail this edit if 100% of their records are reported in one Source of Admission data element category.

Use the Data Distribution Report, in conjunction with the Comparative Edit Summary Report, to help you determine if data is in error or is correct as reported.

Comparative Edit Summary Report

This report identifies the data element categories that have been flagged with a C flag. The report is in alphabetical order by data element and includes the data element category; percentage of records reported (Current Report Period); the “Allowable Percentage” (if applicable); and the corresponding C flag.

To access this report: Click on “Error Reports” on the Main Menu, then under “Edit Programs-Comparative Edits (C)”, click on “View” under “Summary Report”. You can print and/or save this PDF report.

Data Distribution Report

This is a 3-page report that displays each data element and lists the numerical and percentage breakdown of records within each data element category. Use this report to compare the data element categories that have been flagged with a “C” flag to those categories (within the same data element) that were not flagged.

To access this report: From the Main Menu, click on “Error Reports”, then under Informational Reports, click on “View” next to “Data Distribution Report”. You can print and/or save this PDF report.

Report by Selected Data Element (custom report)

When reviewing the Comparative Edit Summary Report, you may need to review records associated with a Comparative Edit Flag. For example, Type of Admission (TOA)-Unknown has a C014 flag— “the number of TOA-Unknown is above the percentage expected for your facility”. In order to correct these records, it would be helpful to generate a report that lists all records reported as Type of Admission-Unknown.

You may need to contact your OSHPD analyst and request a “Report by Selected Data Element”. This custom report, (all records reported as TOA-Unknown, sorted by Abstract Record Number), can be generated and posted on MIRCal. It can then be accessed by the facility and used for Trend Edit error analysis. The report can only be accessed by the requesting facility.

NOTE: *If it is determined that the current data submitted is accurate, please contact your OSHPD Analyst to explain.*

CRITICAL COMPARATIVE EDIT FLAGS AND DESCRIPTIONS

Comparative Edit Flag	Description
C001	All records (100%) are reported in one Sex category: Male or Female
C002	Records reported as Sex-Other are more than 0.1% of total records reported.
C003	Records reported as Sex-Unknown are more than 0.1% of total records reported.
C004	All records (100%) are reported in one Ethnicity category.
C005	Records reported as Ethnicity-Unknown are above the percentage expected for your hospital.
C006	All records (100%) are reported in one Race category.
C007	Records reported as Race-Unknown are above the percentage expected for your hospital.
C008	Partial ZIP Code: Records reported are above the percentage expected for your hospital.
C009	Unknown ZIP Code (XXXXX): Records reported are above the percentage expected for your hospital.
C010	Foreign ZIP Code (YYYYY): Records reported are above the percentage expected for your hospital.
C011	Homeless ZIP Code (ZZZZZ): Records reported are above the percentage expected for your hospital.
C012	All records (100%) are reported in one category for Source of Admission – Site.
C013	Records reported as Source of Admission-Other are above the percentage expected for your hospital.
C014	Records reported as Type of Admission-Unknown are above the percentage expected for your hospital.
C015	All records (100%) are reported in one Patient Disposition category.
C016	Records reported as Patient Disposition-Other are above the percentage expected for your hospital.
C017	All records (100%) are reported in one “Payer” category for Expected Source of Payment.
C018	Expected Source of Payment: All records reported with a Type of Coverage “1” (HMO) have the same Plan Code.
C019	Expected Source of Payment: More than 10% of records with Type of Coverage “1” (HMO) are reported with Plan Code 8000.
C020	No Other Diagnoses Codes reported.
C021	No Principal Procedure reported on any records.
C022	No Other Procedures reported on Type of Care “1” (Acute Care) records.

Comparative Edit Flag	Description
C023	No Other Procedures reported on Type of Care “3” (Skilled Nursing/Intermediate Care) records.
C024	No Other Procedures reported on Type of Care “4” (Psychiatric Care) records.
C025	Prehospital Care and Resuscitation (DNR): All records (100%) are reported as “YES”.
C026	Prehospital Care and Resuscitation (DNR): All Type of Care “1” (Acute Care) records (100%) are reported as “NO”.
C027	Prehospital Care and Resuscitation (DNR): All Type of Care “3” (Skilled Nursing/Intermediate Care) records (100%) are reported as “NO”.
C028	The percentage of records reported with NO, UNKNOWN, and/or CLINICALLY UNDETERMINED for Principal Diagnosis Present on Admission Indicator is greater than 10% of the total number of Principal Diagnosis Indicators reported. Excludes POA reported as ‘blank’, 1 or E for exempt diagnosis codes.
C029	Other Diagnosis Present on Admission Indicators are reported as 100% YES (Y). Excludes POA reported as ‘blank’, 1 or E for exempt diagnosis codes.
C030	The percentage of records reported with NO, UNKNOWN, and/or CLINICALLY UNDETERMINED (W) for Other Diagnosis Present on Admission is greater than <u>30%</u> of the total number of Other Diagnosis Indicators reported. Excludes POA reported as ‘blank’, 1 or E for exempt diagnosis codes.
C031	Principal Diagnosis – 799.9 (Unspecified/Unknown): Percentage of records reported is greater than 0.1%.
C032	All records (100%) are reported in one Type of Admission category.
New! C040	Principal E-Code Present on Admission Indicators are reported as 100% No (N). Excludes POA reported as ‘blank’, 1 or E for exempt E-codes.
New! C041	Principal E-Code Present on Admission Indicators are reported as 100% Unknown (U). Excludes POA reported as ‘blank’, 1 or E for exempt E-codes.
New! C042	Principal E-Code Present on Admission Indicators are reported as 100% Clinically Undetermined (W). Excludes POA reported as ‘blank’, 1 or E for exempt E-codes.
New! C043	Other E-Code Present on Admission Indicators are reported as 100% No (N). Excludes POA reported as ‘blank’, 1 or E for exempt E-codes.
New! C044	Other E-Code Present on Admission Indicators are reported as 100% Unknown (U). Excludes POA reported as ‘blank’, 1 or E for exempt E-codes.
New! C045	Other E-Code Present on Admission Indicators are reported as 100% Clinically Undetermined (W). Excludes POA reported as ‘blank’, 1 or E for exempt E-codes.

VII RECORDS WITH A BLANK OR INVALID PRINCIPAL DIAGNOSIS

OVERVIEW

The “Records with a Blank or Invalid Principal Diagnosis” edit program identifies records with a Principal Diagnosis that is blank, invalid, reported with an “old” diagnosis code after the effective End Date (September 30); or reported with a “new” diagnosis code before the effective Begin Date (October 1). The erroneous Principal Diagnosis code will receive a critical S-flag.

Error Tolerance Level (ETL): Zero Records

Data will be rejected if one or more records fail this edit program.

How do I know if my data failed the “Records with a Blank or Invalid Principal Diagnosis” Edit Program?

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed this edit program. The Summary will display either “Pass” or “Fail”. If data has failed, the summary will display the number of records reported with a blank or invalid Principal Diagnosis.

To access this Summary: click on "Main Error Summary" on the Main Menu.

DEFINITIONS AND REPORTS

Critical (S) Flag

An ‘S’ flag followed by a 3-digit number identifies a critical error. Critical S-flags are applied towards the ETL. If there are one or more records with an S-flag for this edit program, then the data will FAIL the “Records with a Blank or Invalid Principal Diagnosis” edit program and your data will be rejected.

Warning (SW) Flag (Non-Critical Error)

Currently, there are no warning flags for this edit program.

Edit Detail Report of Records with a Blank or Invalid Principal Diagnosis

This report displays all records that received an S001, S002, S059, or S060 on the Principal Diagnosis. The report is sorted by Type of Care, and then by Discharge Date within each Type of Care.

To access this report: From the Main Menu, click on “Error Reports”, then under Informational Reports, click on “View” next to “Records with a Blank/Invalid Principal Diagnosis (S).”

RECORDS WITH A BLANK OR INVALID PRINCIPAL DIAGNOSIS

<i>Critical Edit Flag</i>	<i>Description</i>
S001	Principal Diagnosis is Blank.
S002	Principal Diagnosis is invalid.
S059	New Diagnosis Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S060	Old Diagnosis Code is reported <u>AFTER</u> THE Effective End Date (September 30).

Warning (SW) Non-Critical Flags

<i>Warning (Non-Critical)</i>	<i>Description</i>
none	

VIII STANDARD EDIT PROGRAM

OVERVIEW

The Standard Edit Program edits the data reported within each record. There are two (2) types of Standard Edits— Field Edits and Relational Edits. Field edits identify data elements that are blank, incomplete, or invalid. Relational edits identify illogical relationships between two or more data elements within the same record.

Error Tolerance Level (ETL): 2% of records with one or more Critical Standard Edit flags, based on the total records reported. All edit flags in a record are counted as one (1) error.

How do I know if my data failed the Standard Edit Program?

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Standard Edits. The Summary displays either "Pass" or "Fail" and the number and percentage of records with an "S" flag.

To access this Summary: click on "Main Error Summary" on the Main Menu.

DEFINITIONS AND REPORTS

Critical Standard (S) Edit Flag

An "S" flag, followed by a 3-digit number, identifies a Critical Standard Edit Flag. Critical S-flags are applied towards the ETL. If there are more than 2% of records with one or more S-flags, then the data will FAIL the Standard Edit Validation.

Standard Edit Warning (SW) Flag (Non-Critical Error)

An "SW" flag, followed by a 2-digit number, identifies a Warning Standard Edit Flag. SW-flags will not cause the data to be rejected since they are not applied towards the ETL. These warning flags are provided to alert the facility to review possible errors in the data.

Standard Edit Summary Report

This report displays all data elements with Standard Edit flags. There are two (2) tables— one for data elements that have S-flags and one for data elements that have SW-flags. In each table, the data elements are listed in alphabetical order and include the number, flag, and percentage of S or SW flags within each data element. Use this report to make sure that all errors are located and reviewed or corrected within each record.

Standard Edit Detail Report

This report displays records that have one or more S or SW flags. The report is sorted by Type of Care, and then by Discharge Date within each Type of Care.

To access these reports: Click on "Error Reports" on the Main Menu.

EXPECTED SOURCE OF PAYMENT (ESOP)

The ESOP data element is made up of three components: Payer Category, Type of Coverage and Name of Plan. The Standard Edit Program includes edits that identify records reported with an “illogical combination” of ESOP, i.e., 2 or more of the ESOP components have been reported incorrectly.

Standard Edit Flags for Illogical combinations of ESOP:

Critical Flags: S062, S063, S064

Warning Flags: none

Below is a reference guide to assist you in making corrections to these errors:

Valid ESOP Combinations

For Payer Category:	If Type of Coverage is:	Then HMO Plan Code Number is: (Knox-Keene or MCHOS Plans)
01, 02, 03, 04, 05, 06	1 Knox-Keene (HMO) or MCOHS Plan	Valid Plan Code Number
01, 02, 03, 04, 05, 06	2 Managed Care - Other (PPO, IPO, POS, etc.)	0000
01, 02, 03, 04, 05, 06	3 Traditional Coverage (Fee for Service)	0000
07, 08, 09	0 No Coverage	0000

INVALID SOCIAL SECURITY NUMBER (SSN) RANGES

SSN's with the following numbers are flagged as invalid (S002):

- 7 or 8 identical numbers (except 000000001 – Unknown SSN)
- 9 identical numbers
- The first three (3) numbers are:
 - 000
 - 666
 - 734 through 749
 - 773 through 999
- The last 4 numbers are 0000
- Alpha characters
- 4th and 5th digits are 00

CRITICAL STANDARD EDIT FLAGS AND DESCRIPTIONS

<i>Critical Standard Edit Flag</i>	<i>Description</i>
S001	Blank. No data reported.
S002	Invalid. Data reported is not a valid OSHPD value.
S004	Date of Birth and Admit Date are not the same, but Type of Admission is "Infant, under 24 hours old".
S005	Type of Care is "3" (Skilled Nursing Care) and Source of Admission is reported as "SN/IC-This Hospital". This is an illogical combination.
S006	Admission Date and Date of Birth are the same, but the combination of Source of Admission and Principal Diagnosis is illogical on a newborn record.
S007	Date of Birth is AFTER the Admission Date.
S008	Principal Diagnosis indicates Newborn, but the Type of Admission is <u>not</u> reported as "3" - Infant, under 24 hours old.
S009	Admission Date is AFTER the Discharge Date.
S010	The combination of Source of Admission and Principal Diagnosis is illogical on a Newborn record.
S011	Sex is illogical with Male Principal Diagnosis Code.
S012	Source of Admission is reported as "712" – Newborn, but the Type of Care is not reported as "1" – Acute Care.
S013	Principal Procedure Date is after the Discharge Date.
S016	Date of Birth and Admission Date are not the same, but Principal Diagnosis indicates Newborn (born in the hospital).
S017	Type of Care is reported as "SN/IC" and Patient Disposition is reported as "SN/IC". This is an illogical combination.
S018	Duplicate Diagnoses codes reported.
S019	Principal procedure is Blank, yet Other Procedures are reported.
S020	Source of Admission "911" only applies to infants born <u>before</u> admission to the hospital.
S021	Age is illogical for the Principal Diagnosis reported.
S023	Place of Occurrence E-Code is required.
S024	Principal Procedure Date reported is more than three days <u>before</u> the Admission Date.
S025	Missing Principal Cause of Injury E-Code. The Cause of Injury E-Code is required for the reported Principal Diagnosis. NOTE: If your facility is the first episode of care* for this injury, poisoning, or adverse effect being treated or diagnosed, then the Principal E-Code must be reported on the record. If your facility is not the first episode of care*, then do not report the E-Code. <i>*First episode of care includes ED or AS encounter, or hospital admission (discharge record). It does not include doctor's office.</i>

Critical Standard Edit Flag	Description
S027	Expected Source of Payment: Medicare is illogical with patient's age. Patient is less than 15 years old.
S029	Place of Occurrence E-Code cannot be the Principal E-Code.
S030	"Home-this Hospital" is an illogical combination for Source of Admission. HOME conflicts with <u>Licensure of Site</u> THIS HOSPITAL.
S031	"Home-Another Hospital" is an illogical combination for Source of Admission. HOME conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL.
S032	"Residential Care-This Hospital" is an illogical combination for Source of Admission. RESIDENTIAL CARE conflicts with <u>Licensure of Site</u> THIS HOSPITAL .
S033	"Residential Care-Another Hospital" is an illogical combination for Source of Admission. RESIDENTIAL CARE conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL .
S034	"Acute Inpatient Care-Not a Hospital" is an illogical combination for Source of Admission. ACUTE INPATIENT conflicts with <u>Licensure of Site</u> NOT A HOSPITAL.
S035	"Other Inpatient Care-Not a Hospital" is an illogical combination for Source of Admission. OTHER INPATIENT conflicts with <u>Licensure of Site</u> NOT A HOSPITAL.
S036	"Newborn-Through your ER" is an illogical combination for Source of Admission. NEWBORN conflicts with <u>Route</u> YOUR ER.
S037	"Newborn-Another Hospital" is an illogical combination for Source of Admission. NEWBORN conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL.
S038	"Newborn-Not a Hospital" is an illogical combination for Source of Admission. NEWBORN conflicts with <u>Licensure of Site</u> NOT A HOSPITAL.
S039	"Prison/Jail-This Hospital" is an illogical combination for Source of Admission. PRISON/JAIL conflicts with <u>Licensure of Site</u> THIS HOSPITAL.
S040	"Prison/Jail-Another Hospital" is an illogical combination for Source of Admission. PRISON/JAIL conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL.
S041	"Other-This Hospital/Not your ER" is an illogical combination for Source of Admission. OTHER conflicts with <u>Licensure of Site</u> THIS HOSPITAL and with <u>Route</u> NOT YOUR ER.

Critical Standard Edit Flag	Description
S042	Source of Admission is "SN/IC-This Hospital". Your hospital is <u>not licensed</u> for SN/IC type of care.
S043	Source of Admission is "Acute Care-This Hospital". Your hospital is <u>not licensed</u> for this type of care.
S044	Source of Admission is "Other Care-This Hospital". Your hospital is <u>not licensed</u> for Psychiatric, Chemical Dependency or Physical Rehabilitation types of care.
S045	Patient Disposition is "Acute Care-Within This Hospital". Your hospital is <u>not licensed</u> for this type of care.
S046	Patient Disposition is "Other Care-This Hospital". Your hospital is <u>not licensed</u> for Psychiatric, Chemical Dependency, or Physical Rehabilitation types of care.
S047	Patient Disposition is "SN/IC-Within This Hospital". Your hospital is <u>not licensed</u> for this type of care.
S048	Type of Care: Your hospital is <u>not licensed</u> for Acute Care.
S049	Type of Care: Your hospital is <u>not licensed</u> for SN/IC Care.
S050	Type of Care: Your hospital is <u>not licensed</u> for Psychiatric Care.
S051	Type of Care: Your hospital is <u>not licensed</u> for Chemical Dep Care.
S052	Type of Care: Your hospital is <u>not licensed</u> for Physical Rehabilitation Care.
S054	Age of the patient is greater than 120 years old.
S055	Total Charges reported are less than \$100 for Newborn. Principal Diagnosis indicates Newborn.
S056	There are no Other Diagnoses or Other Procedures reported on the Newborn record, but the <u>Charge per Day</u> is greater than \$2,500. Principal Diagnosis indicates Newborn.
S057	Total Charges are blank on Newborn record. Are the charges included on the mother's record? Principal Diagnosis indicates Newborn.
S058	Discharge Date is Out-of-Range for the report period.
S059	New Diagnosis Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S060	Old Diagnosis Code is reported <u>AFTER</u> the Effective End Date (September 30).
S061	Expected Source of Payment: Invalid Plan Code reported.
S062	Expected Source of Payment: Do not report a Plan Code with Type of Coverage '0', '2' or '3'. (Example: 01 3 0000)
S063	Expected Source of Payment: Type of Coverage cannot be '0' for Payer categories 01 through 06. Must report '1', '2', or '3'. (Example: 01 2 0000)

Critical Standard Edit Flag	Description
S064	Expected Source of Payment: Plan Code Number and Type of Coverage must be reported as all zeroes or left blank for Payer categories 07, 08, and 09. (Example: 08 0 0000)
S070	Source of Admission is reported as "Ambulatory Surgery-This Hospital", but your hospital is <u>not licensed</u> for this service.
S071	Source of Admission-Route is reported as "Your ER", but your hospital is <u>not licensed</u> for Emergency Department Services.
S072	Expected Source of Payment: Worker's Compensation is illogical with age of patient (under 15 years old).
S073	Admission Date is not a reasonable date. Example: The Admission Date is more than 20 years before the Discharge Date.
S074	Principal Procedure Date is not a reasonable date. Example: The Principal Procedure Date is more than 20 years before the Discharge Date.
S075	Other Procedure Date is not a reasonable date. Example: The Other Procedure Date is more than 20 years before the Discharge Date.
S076	Type of Care is illogical with Type of Admission "Infant under 24 hrs old".
S077	Source of Admission "Acute Inpatient-This Hospital" is an illogical combination with Type of Care 1 (Acute Care). A patient cannot be admitted to your hospital's Acute Care if they are coming <u>from</u> your hospital's Acute Care.
S080	Date of Birth is after the Discharge Date.
S081	Date of Birth is after the Principal Procedure Date.
S082	Date of Birth is after Other Procedure Date(s).
S083	Source of Admission indicates Newborn with an illogical Type of Admission. The Source of Admission is reported s '712', but Type of Admission is not '3' (Infant under 24 hours old).
S084	Date of Birth and Admit Date are the same, but Type of Admission is not equal to '3' (Infant under 24 hours old).
S086	Sex is illogical with Female Principal Diagnosis.
S087	Sex is illogical with Male Other Diagnoses Code.
S088	Sex is illogical with Female Other Diagnoses Code.
S089	Sex is illogical with Male Principal Procedure Code.
S090	Sex is illogical with Female Principal Procedure Code.
S091	Sex is illogical with Male Other Procedure Code.

Critical Standard Edit Flag	Description
S092	Sex is illogical with Female Other Procedure Code.
S097	Other Procedure Date is after Discharge Date.
S099	Date of Birth and Admission Date are NOT the same, but Source of Admission is reported as Newborn (712).
S100	Type of Care "Acute" and Patient Disposition "Acute Care within this hospital" is an illogical combination. A patient cannot be discharged to Acute Care within your hospital if they are already in your Acute Care.
S102	Duplicate E-Codes reported in Principal E-Code and Other E-Code fields.
S103	Duplicate Other E-Codes reported.
S104	Principal E-Code is blank, yet Other E-Codes are reported.
S105	Age is illogical with Other Diagnoses Code(s).
S106	Age is illogical with Principal Procedure.
S107	Age is illogical with Other Procedure(s).
S108	Age is illogical with Principal E-Code.
S109	Age is illogical with Other E-Code(s).
S110	Other Procedure Date is more than three days <u>before</u> the Admission Date.
S114	New Procedure Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S116	New E-Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S119	Old Procedure Code is reported <u>AFTER</u> the Effective End Date (September 30).
S121	Old E-Code is reported <u>AFTER</u> the Effective End Date (September 30).
New! S129	Principal Diagnosis code is exempt, but POA Indicator is not blank, or reported as 1 or E.
New! S130	Other Diagnosis code is exempt, but POA Indicator is not blank, or reported as 1 or E.
New! S131	Principal E-Code is exempt, but POA Indicator is not blank, or reported as 1 or E.
New! S132	Other E-Code is exempt, but POA Indicator is not blank, or reported as 1 or E.
New! S134	Principal Diagnosis is <u>not exempt</u> , but POA indicator is reported as 1 or E.
New! S135	Other Diagnosis is <u>not exempt</u> , but POA indicator is reported as 1 or E.
New! S136	Principal E-Code is <u>not exempt</u> , but POA indicator is reported as 1 or E.
New! S137	Other E-Code is <u>not exempt</u> , but POA indicator is reported as 1 or E.

WARNING (SW) Non-Critical Flags

Warning (Non-Critical)	Description
SW01	Partial Date of Birth reported. Only the Birth Year is reported for this patient.
SW02	Partial ZIP Code reported.
SW03	The Patient Length of Stay is greater than 180 days. Verify the Admission Date and Discharge Date.
SW04	The Type of Admission is "Scheduled", but the Source of Admission indicates that the patient was admitted through your ER. (Source of Admission-Route) This is an illogical combination.
SW05	Principal Diagnosis: HIV test result reported.
SW06	Other Diagnosis: HIV test result reported.
SW07	Expected Source of Payment: Medicare is reported with an Unknown Social Security Number.
SW11	Based on the length of stay, the Charge per Day is less than \$100 or greater than \$50,000. NOTE: "No Charge" records are excluded from this edit. "No Charge" is reported as \$1 for Total Charges <u>and</u> 09 0 0000 (Other Payer) for the Expected Source of Payment (ESOP).
SW12	Prehospital Care and Resuscitation (DNR): DNR reported as "YES" is unlikely for Psychiatric, Chemical Dependency, or Physical Rehabilitation Type of Care.

IX RE-ADMISSION EDIT PROGRAM

OVERVIEW

The Re-Admission Edit Program edits for discrepancies between records for patients who had more than one inpatient stay within the Report Period. The records are sorted by Social Security Number in order to group together all inpatient stays for the same patient. Using the first record as the “base value”, the data is then edited for discrepancies in Date of Birth, Sex, Race, and ZIP Code reported for the same patient. The Re-Admission Edits also identify possible errors in transfers between types of care within the facility; and admits from and discharges to sources outside the facility.

Error Tolerance Level (ETL): 2% of records with one or more Critical Re-Admission Edit flags, based on the total records reported. All errors in a record are counted as one (1) error.

How do I know if my data failed the Re-Admission Edit Program?

Check the “Main Error Summary for all Edit Programs” to see if your data passed or failed the Re-Admission Edits. The Summary will display either “Pass” or “Fail” and the number and percentage of records with a “K” flag.

To access this Summary: click on “Main Error Summary” on the Main Menu.

DEFINITIONS AND REPORTS

Critical Re-Admission (K) Edit Flag

A “K” flag followed by a 3-digit number identifies a Critical Re-Admission Edit. Critical K-Flags are applied towards the ETL. If there are more than 2% of records with one or more K-flags, then the data will FAIL the Re-Admission Edit Validation.

Re-Admission Warning (KW) Flag (Non-Critical Error)

A “KW” flag, followed by a 2-digit number, identifies a Warning Re-Admission Edit. KW-flags will not cause the data to be rejected since they are not applied towards the ETL. These warning flags are provided to alert the facility to review possible errors in the data.

Re-Admission Summary Report

This report provides a breakdown of the number and type of K and KW flags identified in the data. Another summary in this report displays the type and number of K flags by data element. Use this report to make sure that all errors are located and reviewed or corrected within each record

Re-Admission Edit Detail Report

This report displays all records that have one or more K or KW flags. The records are sorted by Social Security Number and then by Discharge Date, within each group of SSN's.

To access these reports: click on “Error Reports” on the Main Menu.

CRITICAL RE-ADMISSION EDIT FLAGS AND DESCRIPTIONS

Critical Re-Admission Edit Flag	Description																		
K002	<p>Date of Birth does not match with the first record. Date of Birth on subsequent records for the same patient does not match the Date of Birth reported on the first record.</p> <p>Example:</p> <table><tr><td>SSN</td><td>DOB</td></tr><tr><td>Same</td><td>03-11-1952 K002 (First Record)</td></tr><tr><td>Same</td><td>03-11-1952</td></tr><tr><td>Same</td><td>05-11-1952 K002</td></tr><tr><td>Same</td><td>03-11-1952</td></tr></table>	SSN	DOB	Same	03-11-1952 K002 (First Record)	Same	03-11-1952	Same	05-11-1952 K002	Same	03-11-1952								
SSN	DOB																		
Same	03-11-1952 K002 (First Record)																		
Same	03-11-1952																		
Same	05-11-1952 K002																		
Same	03-11-1952																		
K003	<p>Sex does not match with the first record. Sex on subsequent records for the same patient does not match the Sex reported on the first record.</p> <p>Example:</p> <table><tr><td>SSN</td><td>SEX:</td></tr><tr><td>Same</td><td>1 K003 (First Record)</td></tr><tr><td>Same</td><td>2 K003</td></tr><tr><td>Same</td><td>1</td></tr><tr><td>Same</td><td>2 K003</td></tr></table>	SSN	SEX:	Same	1 K003 (First Record)	Same	2 K003	Same	1	Same	2 K003								
SSN	SEX:																		
Same	1 K003 (First Record)																		
Same	2 K003																		
Same	1																		
Same	2 K003																		
K014	<p>Patient Disposition: Patient died and then was re-admitted.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Patient Disposition</td></tr><tr><td>Same</td><td>01 (Home)</td></tr><tr><td>Same</td><td>11 (Died) K014</td></tr><tr><td>Same</td><td>02 (Acute)</td></tr></table>	SSN	Patient Disposition	Same	01 (Home)	Same	11 (Died) K014	Same	02 (Acute)										
SSN	Patient Disposition																		
Same	01 (Home)																		
Same	11 (Died) K014																		
Same	02 (Acute)																		
K025	<p>ADMIT and DISCHARGE DATE OVERLAP for the same patient:</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td></tr><tr><td>Same</td><td>04-20-2000</td><td>04-28-2000</td></tr><tr><td>Same</td><td>05-01-2000</td><td><u>05-10-2000</u></td></tr><tr><td>Same</td><td><u>06-11-2000</u> K025</td><td>06-19-2000 K025</td></tr><tr><td>Same</td><td>04-29-2000 K025</td><td>06-20-2000 K025</td></tr></table>	SSN	Admit Date	Discharge Date	Same	04-20-2000	04-28-2000	Same	05-01-2000	<u>05-10-2000</u>	Same	<u>06-11-2000</u> K025	06-19-2000 K025	Same	04-29-2000 K025	06-20-2000 K025			
SSN	Admit Date	Discharge Date																	
Same	04-20-2000	04-28-2000																	
Same	05-01-2000	<u>05-10-2000</u>																	
Same	<u>06-11-2000</u> K025	06-19-2000 K025																	
Same	04-29-2000 K025	06-20-2000 K025																	
K026	<p>Patient cannot be discharged from and then re-admitted to the same type of care within your hospital (Acute Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td><u>02</u> K026</td><td><u>1</u> K026</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td><u>512</u> K026</td><td></td><td><u>1</u> K026</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		<u>02</u> K026	<u>1</u> K026	Same	05-26-2000	05-30-2000	<u>512</u> K026		<u>1</u> K026
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		<u>02</u> K026	<u>1</u> K026														
Same	05-26-2000	05-30-2000	<u>512</u> K026		<u>1</u> K026														

Critical Re-Admission Edit Flag	Description																		
K027	<p>Patient cannot be discharged from and then re-admitted to the same type of care within your hospital (SN/IC Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>04 K027</td><td>3 K027</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>411 K027</td><td></td><td>3 K027</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		04 K027	3 K027	Same	05-26-2000	05-30-2000	411 K027		3 K027
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		04 K027	3 K027														
Same	05-26-2000	05-30-2000	411 K027		3 K027														
K028	<p>Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Psychiatric Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03 K028</td><td>4 K028</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>612 K028</td><td></td><td>4 K028</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03 K028	4 K028	Same	05-26-2000	05-30-2000	612 K028		4 K028
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03 K028	4 K028														
Same	05-26-2000	05-30-2000	612 K028		4 K028														
K029	<p>Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Chem Dep Care)</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03 K029</td><td>5 K029</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>611 K029</td><td></td><td>5 K029</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03 K029	5 K029	Same	05-26-2000	05-30-2000	611 K029		5 K029
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03 K029	5 K029														
Same	05-26-2000	05-30-2000	611 K029		5 K029														
K030	<p>Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Physical Rehab Care)</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03 K030</td><td>6 K030</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>612 K030</td><td></td><td>6 K030</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03 K030	6 K030	Same	05-26-2000	05-30-2000	612 K030		6 K030
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03 K030	6 K030														
Same	05-26-2000	05-30-2000	612 K030		6 K030														
K032	<p>Patient Disposition on the first record is 05 (Acute Care at another hospital) but Source of Admission on the re-admit records is not 521 or 522 (Acute Care at another hospital).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Admission</td><td>Pt Disposition</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>05 K032</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>612 K032</td><td></td></tr></table>	SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition	Same	04-20-2000	05-26-2000		05 K032	Same	05-26-2000	05-30-2000	612 K032				
SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition															
Same	04-20-2000	05-26-2000		05 K032															
Same	05-26-2000	05-30-2000	612 K032																
K033	<p>Patient Disposition on the first record is 06 (Other Care at another hospital) but Source of Admission on the re-admit records is not 621 or 622 (Other Care at another hospital).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Admission</td><td>Pt Disposition</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>06 K033</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>612 K033</td><td></td></tr></table>	SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition	Same	04-20-2000	05-26-2000		06 K033	Same	05-26-2000	05-30-2000	612 K033				
SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition															
Same	04-20-2000	05-26-2000		06 K033															
Same	05-26-2000	05-30-2000	612 K033																

Critical Re-Admission Edit Flag	Description															
K034	<p>Patient Disposition on the first record is 07 (SN/IC at another hospital) but Source of Admission on the re-admit records is not 421, 422, 431 432 (SN/IC at another hospital/facility).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Admission</td><td>Pt Disposition</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>07 K034</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>521 K034</td><td></td></tr></table>	SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition	Same	04-20-2000	05-26-2000		07 K034	Same	05-26-2000	05-30-2000	521 K034	
SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition												
Same	04-20-2000	05-26-2000		07 K034												
Same	05-26-2000	05-30-2000	521 K034													
K035	<p>Patient Disposition on the first record is not 05 (Acute Care at another hospital) but Source of Admission on the re-admit records is 521 or 522 (Acute Care at another hospital).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Admission</td><td>Pt Disposition</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>01 K035</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>522 K032</td><td></td></tr></table>	SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition	Same	04-20-2000	05-26-2000		01 K035	Same	05-26-2000	05-30-2000	522 K032	
SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition												
Same	04-20-2000	05-26-2000		01 K035												
Same	05-26-2000	05-30-2000	522 K032													
K036	<p>Patient Disposition on the first record is not 06 (Other Care at another hospital) but Source of Admission on the re-admit records is 621 or 622 (Other Care at another hospital).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Admission</td><td>Pt Disposition</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>05 K036</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>621 K036</td><td></td></tr></table>	SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition	Same	04-20-2000	05-26-2000		05 K036	Same	05-26-2000	05-30-2000	621 K036	
SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition												
Same	04-20-2000	05-26-2000		05 K036												
Same	05-26-2000	05-30-2000	621 K036													
K037	<p>Patient Disposition on the first record is not 07 (SN/IC at another hospital) but Source of Admission on the re-admit records is 421, 22, 431, 432 (SN/IC at another hospital).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Admission</td><td>Pt Disposition</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>05 K037</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>431 K037</td><td></td></tr></table>	SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition	Same	04-20-2000	05-26-2000		05 K037	Same	05-26-2000	05-30-2000	431 K037	
SSN	Admit Date	Discharge Date	Source of Admission	Pt Disposition												
Same	04-20-2000	05-26-2000		05 K037												
Same	05-26-2000	05-30-2000	431 K037													
K038	<p>Type of Care on the first record is not 1 (Acute Care) but Source of Admission on the re-admit record is 511 or 512 (Your Acute Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Type of Care</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>5 K038</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>512 K038</td><td></td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Type of Care	Same	04-20-2000	05-26-2000		5 K038	Same	05-26-2000	05-30-2000	512 K038	
SSN	Admit Date	Disch Date	Source of Admission	Type of Care												
Same	04-20-2000	05-26-2000		5 K038												
Same	05-26-2000	05-30-2000	512 K038													

Critical Re-Admission Edit Flag	Description																		
K039	<p>Type of Care on the first record is not 3 (SN/IC) but Source of Admission on the re-admit record is 411 or 412 (Your SN/IC Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Type of Care</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>5 K039</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>411 K039</td><td></td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Type of Care	Same	04-20-2000	05-26-2000		5 K039	Same	05-26-2000	05-30-2000	411 K039				
SSN	Admit Date	Disch Date	Source of Admission	Type of Care															
Same	04-20-2000	05-26-2000		5 K039															
Same	05-26-2000	05-30-2000	411 K039																
K041	<p>Type of Care on the first record is 1 (Acute Care) but Source of Admission on the re-admit record is not 511 or 512 (Your Acute Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03</td><td>1 K041</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>411 K041</td><td></td><td></td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03	1 K041	Same	05-26-2000	05-30-2000	411 K041		
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03	1 K041														
Same	05-26-2000	05-30-2000	411 K041																
K042	<p>Type of Care on the first record is 3 (SN/IC) but Source of Admission on the re-admit record is not 411 or 412 (Your SN/IC Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03</td><td>3 K042</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>921 K042</td><td></td><td></td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03	3 K042	Same	05-26-2000	05-30-2000	921 K042		
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03	3 K042														
Same	05-26-2000	05-30-2000	921 K042																
K043	<p>Type of Care on the first record is 4, 5, or 6 (Psych, Chem Dep or Phys Rehab Care) but Source of Admission on the re-admit record is not 611 or 612 (Your Other Care).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>02</td><td>6 K043</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>411 K043</td><td></td><td></td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		02	6 K043	Same	05-26-2000	05-30-2000	411 K043		
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		02	6 K043														
Same	05-26-2000	05-30-2000	411 K043																
K044	<p>Patient Disposition on the first record is 02 (Your Acute Care) but Type of Care on the re-admit record is not 1 (Acute Care)</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Pt Disposition</td><td>Type of Care</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td>02 K044</td><td></td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td></td><td>6 K044</td></tr></table>	SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care	Same	04-20-2000	05-26-2000	02 K044		Same	05-26-2000	05-30-2000		6 K044			
SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care															
Same	04-20-2000	05-26-2000	02 K044																
Same	05-26-2000	05-30-2000		6 K044															

Critical Re-Admission Edit Flag	Description																		
K045	<p>Patient Disposition on the first record is 03 (Your Other Care), but Type of Care on the re-admit record is not 4, 5, or 6 (Psych, Chem Dep or Phys Rehab Care)</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Pt Disposition</td><td>Type of Care</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td>03 K045</td><td></td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td></td><td>1 K045</td></tr></table>	SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care	Same	04-20-2000	05-26-2000	03 K045		Same	05-26-2000	05-30-2000		1 K045			
SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care															
Same	04-20-2000	05-26-2000	03 K045																
Same	05-26-2000	05-30-2000		1 K045															
K046	<p>Patient Disposition on the first record is 04 (Your SN/IC Care) but Type of Care on the re-admit record is not 3 (SN/IC Care)</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Pt Disposition</td><td>Type of Care</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td>04 K046</td><td></td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td></td><td>4 K046</td></tr></table>	SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care	Same	04-20-2000	05-26-2000	04 K046		Same	05-26-2000	05-30-2000		4 K046			
SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care															
Same	04-20-2000	05-26-2000	04 K046																
Same	05-26-2000	05-30-2000		4 K046															
K048	<p>Patient Disposition on the first record is not 03 (Your Other Care) but Type of Care on the re-admit record is 4, 5 or 6 (Psych, Chem Dep or Phys Rehab Care)</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>02 K048</td><td></td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>411</td><td></td><td>6 K048</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		02 K048		Same	05-26-2000	05-30-2000	411		6 K048
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		02 K048															
Same	05-26-2000	05-30-2000	411		6 K048														
K049	<p>Patient Disposition on the first record is not 04 (Your SN/IC Care) but Type of Care on the re-admit record is 3 (SN/IC).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-200</td><td>03 K049</td><td></td></tr><tr><td>Same</td><td>5-26-2000</td><td>05-30-2000</td><td></td><td>3 K049</td></tr></table>	SSN	Admit Date	Discharge Date	Pt Dispo	TOC	Same	04-20-2000	05-26-200	03 K049		Same	5-26-2000	05-30-2000		3 K049			
SSN	Admit Date	Discharge Date	Pt Dispo	TOC															
Same	04-20-2000	05-26-200	03 K049																
Same	5-26-2000	05-30-2000		3 K049															
K050	<p>Type of Care on the first record and on the re-admit record is 4 (Psych Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>02 K050</td><td>4 K050</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>611 K050</td><td></td><td>4 K050</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		02 K050	4 K050	Same	05-26-2000	05-30-2000	611 K050		4 K050
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		02 K050	4 K050														
Same	05-26-2000	05-30-2000	611 K050		4 K050														

Critical Re-Admission Edit Flag	Description																		
K051	<p>Type of Care on the first record and on the re-admit record is 5 (Chem Dep Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>02 K051</td><td>5 K051</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>612 K051</td><td></td><td>5 K051</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		02 K051	5 K051	Same	05-26-2000	05-30-2000	612 K051		5 K051
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		02 K051	5 K051														
Same	05-26-2000	05-30-2000	612 K051		5 K051														
K052	<p>Type of Care on the first record and on the re-admit record is 6 (Phys Rehab Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>04 K052</td><td>6 K052</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>611 K052</td><td></td><td>6 K052</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		04 K052	6 K052	Same	05-26-2000	05-30-2000	611 K052		6 K052
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		04 K052	6 K052														
Same	05-26-2000	05-30-2000	611 K052		6 K052														
K053	<p>Expected Source of Payment does not match on same day re-admit records.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Payment</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td>0800000 K053</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>0320000 K053</td></tr></table>	SSN	Admit Date	Discharge Date	Source of Payment	Same	04-20-2000	05-26-2000	0800000 K053	Same	05-26-2000	05-30-2000	0320000 K053						
SSN	Admit Date	Discharge Date	Source of Payment																
Same	04-20-2000	05-26-2000	0800000 K053																
Same	05-26-2000	05-30-2000	0320000 K053																
K054	<p>Same Principal E-Code is reported on re-admit record.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Principal E-Code</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td>E989 K054</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>E989 K054</td></tr></table>	SSN	Admit Date	Discharge Date	Principal E-Code	Same	04-20-2000	05-26-2000	E989 K054	Same	05-26-2000	05-30-2000	E989 K054						
SSN	Admit Date	Discharge Date	Principal E-Code																
Same	04-20-2000	05-26-2000	E989 K054																
Same	05-26-2000	05-30-2000	E989 K054																
K055	<p>Source of Admission on the re-admit record indicates that patient was admitted from “your hospital”, but the Discharge Date on the first record and the Admit Date on the re-admit record are not the same.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Discharge Date</td><td>Source of Admission/ Licensure of Site</td></tr><tr><td>Same</td><td>05-31-2000</td><td>06-01-2000 K055</td><td>132</td></tr><tr><td>Same</td><td>06-03-2000 K055</td><td>06-15-2000</td><td>512 K055</td></tr></table>	SSN	Admit Date	Discharge Date	Source of Admission/ Licensure of Site	Same	05-31-2000	06-01-2000 K055	132	Same	06-03-2000 K055	06-15-2000	512 K055						
SSN	Admit Date	Discharge Date	Source of Admission/ Licensure of Site																
Same	05-31-2000	06-01-2000 K055	132																
Same	06-03-2000 K055	06-15-2000	512 K055																

Critical Re-Admission Edit Flag	Description																		
K056	<p>Type of Care on the first record and on the re-admit record is 4 (Psych Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03 K056</td><td>4 K056</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>511 K056</td><td></td><td>4 K056</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03 K056	4 K056	Same	05-26-2000	05-30-2000	511 K056		4 K056
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03 K056	4 K056														
Same	05-26-2000	05-30-2000	511 K056		4 K056														
K057	<p>Type of Care on the first record and on the re-admit record is 5 (Chem Dep Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03 K057</td><td>5 K057</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>412 K057</td><td></td><td>5 K057</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03 K057	5 K057	Same	05-26-2000	05-30-2000	412 K057		5 K057
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03 K057	5 K057														
Same	05-26-2000	05-30-2000	412 K057		5 K057														
K058	<p>Type of Care on the first record and on the re-admit record is 6 (Phys Rehab Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>03 K058</td><td>6 K058</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>132 K058</td><td></td><td>6 K058</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		03 K058	6 K058	Same	05-26-2000	05-30-2000	132 K058		6 K058
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		03 K058	6 K058														
Same	05-26-2000	05-30-2000	132 K058		6 K058														
K059	<p>Source of Admission on the re-admit record is 411, 412, 511, 512, 611, or 612 (admitted from care within your hospital), but the Patient Disposition on the previous record is not 02, 03 or 04 (discharged from care within your hospital).</p> <p>Example:</p> <table><tr><td>SSN</td><td>Admit Date</td><td>Disch Date</td><td>Source of Admission</td><td>Pt Dispo</td><td>TOC</td></tr><tr><td>Same</td><td>04-20-2000</td><td>05-26-2000</td><td></td><td>01 K059</td><td>3</td></tr><tr><td>Same</td><td>05-26-2000</td><td>05-30-2000</td><td>411 K059</td><td></td><td>1</td></tr></table>	SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		01 K059	3	Same	05-26-2000	05-30-2000	411 K059		1
SSN	Admit Date	Disch Date	Source of Admission	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		01 K059	3														
Same	05-26-2000	05-30-2000	411 K059		1														

WARNING RE-ADMISSION EDIT FLAGS AND DESCRIPTIONS (Non-Critical Flags)

Warning (Non-Critical) Re-Admission Edit Flag	Description																														
KW01	<p>Ethnicity and/or Race does not match with the first record. Ethnicity and/or Race on re-admit records for the same patient does not match the Ethnicity and/or Race reported on the first record.</p> <p>NOTE: Psychiatric Type of Care records are excluded from this edit, EXCEPT for “Same Day Re-Admits”— the Discharge Date on the first record is the same as the Admit Date on the re-admit record.</p> <p>Example: The Ethnicity and/or Race reported on the third record is not the same and is flagged based on the Ethnicity and/or Race reported on the first record.</p> <table><tr><th>SSN</th><th>RACE</th><th>ADMIT DATE</th><th>DISCHARGE DATE</th><th>TOC</th></tr><tr><td>Same</td><td>11 KW01</td><td>5-1-2000</td><td>5-2-2000</td><td>1</td></tr><tr><td>Same</td><td>21</td><td>5-3-2000</td><td><u>5-5-2000</u></td><td><u>4</u></td></tr><tr><td>Same</td><td>31 KW01</td><td><u>5-5-2000</u></td><td>6-6-2000</td><td>1</td></tr><tr><td>Same</td><td>32</td><td>7-9-2000</td><td>7-11-2000</td><td>4</td></tr></table>	SSN	RACE	ADMIT DATE	DISCHARGE DATE	TOC	Same	11 KW01	5-1-2000	5-2-2000	1	Same	21	5-3-2000	<u>5-5-2000</u>	<u>4</u>	Same	31 KW01	<u>5-5-2000</u>	6-6-2000	1	Same	32	7-9-2000	7-11-2000	4					
SSN	RACE	ADMIT DATE	DISCHARGE DATE	TOC																											
Same	11 KW01	5-1-2000	5-2-2000	1																											
Same	21	5-3-2000	<u>5-5-2000</u>	<u>4</u>																											
Same	31 KW01	<u>5-5-2000</u>	6-6-2000	1																											
Same	32	7-9-2000	7-11-2000	4																											
KW02	<p>ZIP Code does not match with the first record. ZIP Code on subsequent records for the same patient does not match the ZIP Code reported on the first record.</p> <p>NOTE: Psychiatric Type of Care records are excluded from this edit, EXCEPT for “Same Day Re-Admits”— the Discharge Date on the first record is the same as the Admit Date on the re-admit record.</p> <p>Example: The ZIP Code reported for this patient is not the same and is flagged based on the ZIP Code reported on the <u>first</u> record.</p> <table><tr><th>SSN</th><th>ZIP CODE</th><th>ADMIT DATE</th><th>DISCHARGE DATE</th><th>TOC</th></tr><tr><td>Same</td><td>95608 KW02</td><td>5-1-2000</td><td>5-2-2000</td><td>1</td></tr><tr><td>Same</td><td>95864</td><td>5-3-2000</td><td>5-5-2000</td><td>4</td></tr><tr><td>Same</td><td>95608</td><td>6-1-2000</td><td>6-4-2000</td><td><u>1</u></td></tr><tr><td>Same</td><td>95864 KW02</td><td>6-5-2000</td><td><u>6-6-2000</u></td><td>1</td></tr><tr><td>Same</td><td>95825</td><td><u>6-6-2000</u></td><td>6-8-2000</td><td><u>4</u></td></tr></table>	SSN	ZIP CODE	ADMIT DATE	DISCHARGE DATE	TOC	Same	95608 KW02	5-1-2000	5-2-2000	1	Same	95864	5-3-2000	5-5-2000	4	Same	95608	6-1-2000	6-4-2000	<u>1</u>	Same	95864 KW02	6-5-2000	<u>6-6-2000</u>	1	Same	95825	<u>6-6-2000</u>	6-8-2000	<u>4</u>
SSN	ZIP CODE	ADMIT DATE	DISCHARGE DATE	TOC																											
Same	95608 KW02	5-1-2000	5-2-2000	1																											
Same	95864	5-3-2000	5-5-2000	4																											
Same	95608	6-1-2000	6-4-2000	<u>1</u>																											
Same	95864 KW02	6-5-2000	<u>6-6-2000</u>	1																											
Same	95825	<u>6-6-2000</u>	6-8-2000	<u>4</u>																											

X CODING EDITS

REFER TO THE CODING EDIT MANUAL FOR CRITICAL AND NON-CRITICAL CODING EDIT FLAGS AND DESCRIPTIONS

This manual is available on the MIRCal website at:
<http://www.oshpd.ca.gov/HID/MIRCal/ICD9CodingManual.html>

Error Tolerance Level (ETL): 2% of records with one or more Critical Coding Edit flags, based on the total records reported. All errors in a record are counted as one (1) error.

DEFINITIONS AND REPORTS

Critical Coding (V) Edit Flag

A “V” flag, followed by a 3-digit number, identifies a Critical Coding Edit Flag. Critical V flags are applied towards the ETL. If there are more than 2% of records with one or more V flags, then the data will FAIL the Coding Edit Validation.

Coding Warning (VW) Flag (Non-Critical Error)

A “VW” flag, followed by a 2-digit number, identifies a Warning Coding Edit Flag. VW flags will not cause the data to be rejected since they are not applied towards the ETL. These warning flags are provided to alert the facility to review possible errors in the data.

Coding Summary Report

This report provides a breakdown of the number and type of V and VW flags identified in the data. Use this report to make sure that all errors are located and reviewed or corrected within each record.

Coding Edit Detail Report

This report displays all records that have one or more V or VW flags. The report is sorted by Type of Care, and then by Discharge Date within each Type of Care.

To access these reports: click on “Error Reports” on the Main Menu.

XI EXCEPTION EDIT PROGRAM

OVERVIEW

Exception edits are non-critical and are not applied to the ETL. Data cannot be rejected due to Exception Edits. Exception Edits identify the possible over-reporting or under-reporting of certain data element values. For example, an Exception Edit will alert the facility that there are no records reported with Homeless ZIP Codes (ZZZZZ); or that 15% or more of the records are reported with an Unknown Social Security Number. The facility may want to review the data to determine if errors exist in the data.

An X-flag followed by a 3-digit number identifies an Exception Edit.

How do I know if I have Exception Edits?

Check the "Main Error Summary for all Edit Programs" to see if you have any Exception Edits. The Summary will display the number of Exception Edits in the data.

To access this Summary: click on "Main Error Summary" on the Main Menu.

DEFINITIONS AND REPORTS

Exception Edit Summary Report

This report lists the Exception Edit Flags and descriptions that identify possible errors in the data.

Exception Edit Detail Report

This report lists the records that have been flagged with an X007 or X008 flag. All other E flags are based on the logic: "no records reported with...", and therefore there are no records to flag. See next page for a list and description of the Exception Edits.

Data Distribution Report

The Data Distribution Report is a 3-page summary that displays each data element and lists the numerical and percentage breakdown of records within each data element category. This report may be helpful in determining if corrections are needed to the Exception Edit flags.

To access these reports: Click on "Error Reports" on the Main Menu. You can print and/or save these PDF reports.

EXCEPTION EDIT FLAGS AND DESCRIPTIONS

<i>Exception Edit Flag</i>	<i>Description</i>
X003	<p>No E-Code reported on Skilled Nursing Care records, Type of Care 3. Record includes one or more of the following ICD-9 codes in “<u>Other Diagnoses</u>”: 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89.</p> <p>Did patient sustain an injury or adverse effect during their skilled nursing care stay?</p>
X004	<p>No E-Code reported on Psychiatric Care records, Type of Care 4. Record includes one or more of the following ICD-9 codes in “<u>Other Diagnoses</u>”: 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89.</p> <p>Did patient sustain an injury or adverse effect during their psychiatric care stay?</p>
X005	<p>No E-Code reported on Chemical Dependency Care records, Type of Care 5. Record includes one or more of the following ICD-9 codes in “<u>Other Diagnoses</u>”: 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89.</p> <p>Did patient sustain an injury or adverse effect during their chemical dependency care stay?</p>
X006	<p>No E-Code reported on Physical Rehabilitation Care records, Type of Care 6. Record includes one or more of the following ICD-9 codes in “<u>Other Diagnoses</u>”: 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89.</p> <p>Did patient sustain an injury or adverse effect during their physical rehabilitation care stay?</p>
X007	<p>Place of Occurrence E-Code: 50% or more of all Place of Occurrence E-Codes reported are E849.9 (Unspecified). Please review records with an E849.9 and correct to a more specific place of occurrence, if available in the medical record.</p>
X008	<p>Unknown SSN's: The number of records reported with an Unknown SSN is 15 % or more. Please review these records and provide a valid SSN, if available in the medical record.</p> <p>This percentage excludes Unknown SSN's reported on Newborn records.</p>
X009	<p>Source of Admission: Ambulatory Surgery-This Hospital. Your facility is licensed for Ambulatory Surgery, but there are NO RECORDS reported as 311 or 312 in Source of Admission. Please verify that this is correct as reported.</p>
X010	<p>There are NO RECORDS reported with a Homeless ZIP Code. If your facility provides inpatient care to Homeless patients, the ZIP Code must be reported as "ZZZZZ". Do not use the Unknown ZIP Code, XXXXX, for homeless patients.</p>

XII AGE AND SEX EDIT TABLES

AGE EDIT TABLE

<u>ICD-9-CM Diagnosis Code</u>	<u>Age at Admission Invalid if . . .</u>
V23.85	- Age less than 10
V23.86	- Age less than 10 or greater than 70
V28.81 - V28.89	- Age less than 10 or greater than 70
V51.0	- Age Less than 15
V89.01 - V89.09	- Age Less than 10 or greater than 70
V20.0 - V20.2	- Age greater than 18
V22.0 - V23.7	- Age less than 10 or greater than 70
V23.81 - V23.82	- Age less than 35 or greater than 70
V23.83 - V23.84	- Age less than 10 or greater than 15
V23.89 - V24.2	- Age less than 10 or greater than 70
V25.01 - V25.1	- Age less than 10
V25.3 - V25.5	- Age less than 10
V26.0	- Age less than 1 year
V26.1 - V26.22	- Age less than 10
V26.81 - V26.9	- Age less than 10
V27.0 - V28.9	- Age less than 10 or greater than 70
V29.0 - V29.9	- Age greater than 1
V30.00 - V30.1	- Age greater than 1
V31.00 - V31.1	- Age greater than 1
V32.00 - V32.1	- Age greater than 1
V33.00 - V33.1	- Age greater than 1
V34.00 - V34.1	- Age greater than 1
V35.00 - V35.1	- Age greater than 1
V36.00 - V36.1	- Age greater than 1
V37.00 - V37.1	- Age greater than 1
V39.00 - V39.1	- Age greater than 1
V49.81	- Age less than 15
V59.71 - V59.72	- Age greater than 34
V59.73 - V59.74	- Age less than 35
V61.6 - V61.7	- Age less than 10 or greater than 70
V65.11	- Age less than 15 or greater than 70
V71.01	- Age less than 15
V71.02	- Age greater than 18
V72.40 - V72.42	- Age less than 10
V85.0 - V85.4	- Age less than 15
V85.51 - V85.54	- Age greater than 21
259.1	- Age greater than 18
277.01	- Age greater than 2
303.00 - 303.03	- Age less than 5
303.90 - 304.93	- Age less than 10
305.00 - 305.03	- Age less than 5
305.1	- Age less than 10
305.20 - 305.43	- Age less than 5
305.50 - 305.53	- Age less than 10
305.60 - 305.93	- Age less than 5

AGE EDIT TABLE (continued)

<u>ICD-9-CM Diagnosis Code</u>	<u>Age at Admission Invalid if . . .</u>
313.89 - 313.9	- Age greater than 18
331.81	- Age greater than 18
335.20	- Age less than 15
340	- Age less than 11
366.10 - 366.19	- Age less than 15
374.01	- Age less than 15
374.11	- Age less than 15
410.00 - 414.07	- Age less than 15
429.2	- Age less than 15
429.71 - 429.79	- Age less than 15
435.8 - 436	- Age less than 11
437.0	- Age less than 15
440.0 - 440.9	- Age less than 15
441.00 - 442.9	- Age less than 11
454.0 - 454.9	- Age less than 15
457.0	- Age less than 15
496 - 501	- Age less than 15
571.0 - 571.3	- Age less than 15
600.0 - 602.9	- Age less than 15
606.0 - 606.9	- Age less than 15
607.84	- Age less than 15
610.1	- Age less than 15
630. - 659.43	- Age less than 10 or greater than 70
659.50 - 659.63	- Age greater than 70
659.70 - 676.94	- Age less than 10 or greater than 70
678.00 - 679.14	- Age less than 10 or greater than 70
690.11 - 690.12	- Age greater than 18
722.0 - 722.93	- Age less than 15
724.00 - 724.09	- Age less than 15
728.6	- Age less than 15
751.1 - 751.2	- Age greater than 18
751.61	- Age greater than 18
780.91 - 780.92	- Age greater than 2
790.93	- Age less than 15
792.3	- Age less than 10
796.5	- Age less than 10 or greater than 70
798.0	- Age greater than 18
995.50 - 995.59	- Age greater than 18
995.80 - 995.85	- Age less than 15

<u>ICD-9-CM Procedure Code</u>	<u>Age at Admission Invalid if . . .</u>
72.0 - 75.99	- Age less than 10 or greater than 70

<u>ICD-9-CM E-Code</u>	<u>Age at Admission Invalid if . . .</u>
E800.0	- Age less than 14
E801.0	- Age less than 14

AGE EDIT TABLE (continued)

<u>ICD-9-CM E-Code</u>	<u>Age at Admission Invalid if . . .</u>
E802.0	- Age less than 14
E803.0	- Age less than 14
E804.0	- Age less than 14
E805.0	- Age less than 14
E806.0	- Age less than 14
E807.0	- Age less than 14
E810.0	- Age less than 2
E810.2	- Age less than 2
E811.0	- Age less than 2
E811.2	- Age less than 2
E812.0	- Age less than 2
E812.2	- Age less than 2
E813.0	- Age less than 2
E813.2	- Age less than 2
E814.0	- Age less than 2
E814.2	- Age less than 2
E815.0	- Age less than 2
E815.2	- Age less than 2
E816.0	- Age less than 2
E816.2	- Age less than 2
E817.0	- Age less than 2
E817.2	- Age less than 2
E818.0	- Age less than 2
E818.2	- Age less than 2
E819.0	- Age less than 2
E819.2	- Age less than 2
E820.0	- Age less than 2
E820.2	- Age less than 2
E821.0	- Age less than 2
E821.2	- Age less than 2
E822.0	- Age less than 2
E822.2	- Age less than 2
E823.0	- Age less than 2
E823.2	- Age less than 2
E824.0	- Age less than 2
E824.2	- Age less than 2
E825.0	- Age less than 2
E825.2	- Age less than 2
E826.2	- Age less than 2
E827.2	- Age less than 2
E828.2	- Age less than 2
E830.4	- Age less than 2
E830.6	- Age less than 14
E831.4	- Age less than 2
E831.6	- Age less than 14
E832.4	- Age less than 2
E832.6	- Age less than 14

AGE EDIT TABLE (continued)

<u>ICD-9-CM E-Code</u>	<u>Age at admission Invalid if . . .</u>
E833.4	- Age less than 2
E833.6	- Age less than 14
E834.4	- Age less than 2
E834.6	- Age less than 14
E835.4	- Age less than 2
E835.6	- Age less than 14
E836.4	- Age less than 2
E836.6	- Age less than 14
E837.4	- Age less than 2
E837.6	- Age less than 14
E838.4	- Age less than 2
E838.6	- Age less than 14
E840.2	- Age less than 14
E840.7	- Age less than 2
E840.8	- Age less than 14
E841.2	- Age less than 14
E841.7	- Age less than 2
E841.8	- Age less than 14
E842.7	- Age less than 2
E842.8	- Age less than 14
E843.2	- Age less than 14
E843.7	- Age less than 2
E843.8	- Age less than 14
E844.2	- Age less than 14
E844.7	- Age less than 2
E844.8	- Age less than 14
E845.8	- Age less than 14
E950.0 - E959	- Age less than 2

SEX EDIT TABLE

<u>ICD-9-CM Diagnosis Code</u>	<u>Sex Specific</u>
V07.4	Female
V10.40 - V10.44	Female
V10.45 - V10.49	Male
V13.1	Female
V13.21 - V13.29	Female
V13.61	Male
V15.21 - V15.22	Female
V22.0 - V25.01	Female
V25.1	Female
V25.3	Female
V25.41 - V25.43	Female
V25.5	Female
V26.1	Female
V26.34 - V26.35	Male
V26.39	Male
V26.51	Female
V26.52	Male
V27.0 - V28.9	Female
V45.51	Female
V49.81	Female
V50.2	Male
V50.42	Female
V52.4	Female
V59.70 - V59.74	Female
V61.6 - V61.7	Female
V65.11	Female
V67.01	Female
V72.31 - V72.32	Female
V72.40 - V72.42	Female
V76.11	Female
V76.2	Female
V76.44 - V76.45	Male
V76.46 - V76.47	Female
V84.02	Female
V84.03	Male
V84.04	Female
V88.01 - V89.09	Female
016.40 - 016.56	Male
016.60 - 016.76	Female
054.11 - 054.12	Female
054.13	Male
072.0	Male
098.12 - 098.14	Male
098.15 - 098.17	Female
098.32 - 098.34	Male
098.35 - 098.37	Female
112.1	Female

SEX EDIT TABLE (continued)

<u>ICD-9-CM Diagnosis Code</u>	<u>Sex Specific</u>
131.01	Female
131.03	Male
174.0 - 174.9	Female
175.0 - 175.9	Male
179. - 184.9	Female
185. - 187.9	Male
198.6	Female
214.4	Male
218.0 - 221.9	Female
222.0 - 222.9	Male
233.1 - 233.39	Female
233.4 - 233.6	Male
236.0 - 236.3	Female
236.4 - 236.6	Male
256.0 - 256.9	Female
257.0 - 257.1	Male
257.3 - 257.7	Male
257.9	Male
302.73	Female
302.74 -302.75	Male
302.76	Female
306.51 - 306.52	Female
456.4	Male
456.6	Female
600.0 - 608.9	Male
614.0 - 677	Female
716.30 -716.39	Female
752.0 - 752.49	Female
752.51 - 752.69	Male
752.81	Male
758.7	Male
788.32	Male
790.93	Male
792.2	Male
792.3	Female
795.00 - 795.05	Female
795.06	Female
795.08 - 795.09	Female
796.5	Female
867.4 - 867.5	Female
878.0 - 878.3	Male
878.4 - 878.7	Female
902.55 - 902.56	Female
902.81 - 902.82	Female
939.1 - 939.2	Female
939.3	Male
947.4	Female
959.13	Male

SEX EDIT TABLE (continued)

<u>ICD-9-CM Procedure Code</u>	<u>Sex Specific</u>
996.32	Female
60.0 - 64.99	Male
65.01 - 75.99	Female
85.70 - 85.79	Female
87.81 - 87.89	Female
87.91 - 87.99	Male
88.46	Female
88.78	Female
89.26	Female
91.41 - 91.49	Female
92.17	Female
96.14 - 96.18	Female
96.44	Female
97.24 - 97.26	Female
97.71 - 97.75	Female
98.16 - 98.17	Female
98.23	Female
98.24	Male
99.94 - 99.96	Male
99.98	Female